Before the
Administrative Hearing Commission
State of Missouri

STATE BOARD OF NURSING,	)	
	)	
Petitioner,	)	
	)	
vs.	)	No. 13-0504 BN
	)	
PHILIP ROTICH,	)	
	)	
Respondent.	)	

DECISION

Philip Rotich is subject to discipline because he made erroneous entries in a controlled substance medication record and attempted to cover up the errors with deception.

Procedure

On April 2, 2013, the State Board of Nursing ("the Board") filed a complaint seeking to discipline Rotich. On April 15, 2013, Rotich was served by certified mail with a copy of the complaint and our notice of complaint/notice of hearing. He filed an answer on April 30, 2013.

We held a hearing on July 18, 2014. Rodney P. Massman represented the Board. Kevin J. Dolley of the Law Offices of Kevin J. Dolley, LLC, represented Rotich. The case became ready for decision on December 30, 2014, the date the last written argument was due.

Findings of Fact

1. Rotich is licensed by the Board as a registered professional nurse ("RN"). His license was current and active at all relevant times.

2. On April 2, 2010, Rotich began working at Kindred Hospital in Kansas City, Missouri.

3. Kindred Hospital is a long-term, acute-care hospital. The patients admitted to Kindred Hospital often have complicated medical histories and care plans.

4. Rotich's shift was usually 7:00 p.m. to 7:00 a.m. He typically arrived at 6:45 p.m. to accept transfer of the patients for the night shift.

5. On May 28, 2010, Rotich received a counseling memo, called a Performance Improvement Form (or "PI"), alleging that he violated various hospital policies by failing to respond appropriately when asked by a female phlebotomist to stay in a patient room with her while she conducted a blood draw on a potentially dangerous patient.

6. Throughout Rotich's tenure, nursing supervisors worked with staff nurses to improve documentation and control of controlled substances. On November 16, 2010 and March 10, 2011, Rotich received PIs related to controlled substance documentation errors he made.

7. In order to track the flow of controlled substances at Kindred Hospital, the nursing staff and pharmacy used a form called a controlled substance administration record ("CSAR").

8. An RN was assigned responsibility for carrying the narcotics[1] key for each shift. That incoming nurse was tasked with conducting an inventory of the narcotics box with the nurse holding the narcotics key for the previous shift in order to make sure that the narcotics count was accurate and any inaccuracy could be immediately investigated.

[1] Kindred Hospital staff apparently used the word "narcotic," as well as "controlled substances" to refer to the same type of medications. We assume the terms are synonymous for purposes of this decision and use both terms as they appear in the record.

9. Shift changes and narcotics box inventories took place at 7:00 a.m. and 7:00 p.m. At the shift change, the nurse taking over the key for the next shift would sign as the "nurse in" at the bottom of the CSAR, and the nurse with the key for the previous shift would sign as the "nurse out".

10. On October 13, 2011, Rotich took over the narcotics box key when he went on duty at 7:00 p.m. He took part in the count with the outgoing nurse and signed the bottom of the CSAR.

11. Although both Rotich and the outgoing nurse agreed to a count of 7 tablets of Xanax 0.5 mg at the shift change, Rotich failed to notice that the record beginning inventory at the top of the CSAR form listed 8 tablets. This caused the overnight narcotics count for Xanax 0.5 mg to be off by one tablet. There were 7 tablets in the box, but 8 tablets were listed in the beginning inventory.

12. Rotich administered two Xanax 0.5 mg during his shift, both to patient P.A., for which he withdrew two tablets at 22:01 (10:01 p.m.) and 6:58 a.m. After he administered the first, he wrote "7" in the space for the Xanax 0.5 mg count on the CSAR, and after he administered the second, he wrote "6."

13. The next morning, Rotich and the oncoming day shift nurse, Terri Curry, conducted the narcotics box inventory at about 7:00 a.m. They discovered there were only 5 Xanax 0.5 mg in the narcotics box.

14. Rotich was very upset to discover the discrepancy. He did not know what had happened to the missing tablet, and his first thought was that a tablet might have been dropped. Impulsively, he wrote a "C" in the "Dosage wasted" column, indicating the dose had been dropped on the floor, by the 22:01 entry in which he had indicated he had withdrawn a Xanax 0.5 mg tablet for P.A.

15. Kindred's protocol for wasting a controlled substance required two nurse signatures on the CSAR. Rotich asked Curry to help document the waste or destruction of a Xanax 0.5 mg tablet, but Curry declined to sign the CSAR as a witness to the waste of the 0.5 mg tablet because she had not actually seen the tablet wasted.

16. Curry called the day shift supervisor, Vickie Estrada, to report the discrepancy. Rotich left the medication room.

17. Estrada went to the medication room. Seeing that Rotich was not there, she went to find him on the unit.

18. When Estrada questioned Rotich about the count discrepancy, he quickly responded that he had dropped one of the Xanax tablets in a patient room, which would have accounted for a missing tablet, but it was not a true statement.

19. Estrada said she would accompany Rotich back to the patient room to help him look for the missing tablet of Xanax so it could be accounted for and wasted in accordance with hospital policy. Rotich then said he had not dropped a tablet after all.

20. Rotich then went back to the medication room and lined all the way through the 22:01 CSAR entry. He did not change the electronic medical record for patient P.A., however, which showed that Rotich administered the 0.5 mg tablet of Xanax at 10:04 p.m. and had gone back 30 minutes later to document its effect on P.A.'s condition.

21. Rotich then made a late entry for a 22:02 (10:02 p.m.) withdrawal of the Xanax tablet.

22. Rotich was ultimately fired from Kindred Hospital over the mishandling of the narcotics count and his attempts to cover up an error in the count with false documentation in the CSAR.

23. At the time of the hearing, Rotich was working as an RN at a rehabilitation nursing facility and had been named employee of the month there for June.

Evidentiary Ruling

At the hearing, the Board offered its Exhibit B, purportedly records from Kindred Hospital, into evidence. Rotich objected to the exhibit because the names of patients had been blacked out in the copy it had received in discovery, but not at the hearing, and because it claimed expert testimony would be needed to "decipher" them. We overrule these objections. But, for the reasons discussed below, we reserved our ruling on the admissibility of Exhibit B.

Exhibit B consists of 147 pages of what appear to be patient records. The name of Kindred Hospital does not appear on the records. The records are "authenticated" by an affidavit of the director of the Board, which states:

> The 147 page(s) of records are kept by the Board in the regular course of business, and it was the regular course of business of the Board for an employee or representative of the Board with knowledge of the act, event condition [sic], opinion or diagnosis to make the record or to transmit information thereof to be included in such record; and the record was made at or near the time of the act, event, condition, opinion or diagnosis. The records attached hereto are the original, exact duplicates of the original, or accurate reproductions of the original records as permitted by section 490.692[.]

As we observed at the hearing, Exhibit B contains no authentication from Kindred Hospital – not even a cover letter, transmittal sheet, or statement by the Board's investigator to the effect that the records were obtained from Kindred Hospital. Section 536.070(10) provides broad authority for the admissibility of agency records, and the records may be admissible under that authority. But it also provides that other circumstances may affect the weight of the evidence, and we take that into account in this case. We admit the Board's Exhibit B, but we find it so lacking in foundation as to be unreliable, and we give it no weight. We note, however, that the most important of Kindred Hospital's records also appear in Board Exhibit A. Although

Exhibit A was authenticated in the same manner, we find that the hospital records contained therein are accompanied by cover correspondence from Kindred Hospital staff and were also the subject of testimony given at the hearing by Kindred Hospital's chief clinical officer. Thus, we find the records in Exhibit A to be sufficiently reliable to serve as evidence in this case.

Conclusions of Law

We have jurisdiction to hear this case. Sections 335.066.2 and 621.045.[2] The Board bears the burden of proving that Rotich's license is subject to discipline by a preponderance of the evidence. *See Kerwin v. Mo. Dental Bd.*, 375 S.W.3d 219, 229-30 (Mo. App. W.D. 2012)(dental licensing board demonstrates "cause" to discipline by showing preponderance of evidence). A preponderance of the evidence is evidence showing, as a whole, that "the fact to be proved [is] more probable than not." *Id.* at 230 (*quoting State Bd. of Nursing v. Berry*, 32 S.W.3d 638, 642 (Mo. App. W.D. 2000)). This Commission must judge the credibility of witnesses and the weight and value to be given to their testimony. *Koetting v. State Bd. of Nursing*, 314 S.W.3d 812, 815 (Mo.App. W.D. 2010). Our findings of fact reflect our credibility assessments.

Cause for Discipline

The Board alleges that there is cause for discipline under § 335.066:[3]

> 2. The board may cause a complaint to be filed with the administrative hearing commission as provided by chapter 621 against any holder of any certificate of registration or authority, permit or license required by sections 335.011 to 335.096 or any person who has failed to renew of has surrendered his or his certificate of registration or authority, permit or license for any one or any combination of the following causes:
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> * * *

[2] Statutory references are to RSMo Supp. 2013 unless otherwise noted.

[3] RSMo Supp. 2010. Since the alleged misconduct occurred between April 2, 2010 and October 14, 2011, the 2010 supplement contains the statutory provisions governing cause for discipline at the relevant time.

> (5) Incompetency, misconduct, gross negligence, fraud, misrepresentation or dishonesty in the performance of the functions or duties of any profession licensed or regulated by sections 335.011 to 335.096;
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> * * *
>
> (12) Violation of any professional trust or confidence[.]

Professional Standards – Subdivision (5)

The Board alleges in its complaint that Rotich's performance history at Kindred Hospital, including the several PIs as well as the "Xanax incident," establishes cause to discipline his nursing license for misconduct, fraud, dishonesty, and misrepresentation in the performance of his functions and duties as an RN. In its brief, however, the Board argues only that the Xanax incident is cause for discipline under 335.066.2(5), so we address that issue only.

Misconduct means "the willful doing of an act with a wrongful intention[;] intentional wrongdoing." *Missouri Bd. for Arch'ts, Prof'l Eng'rs & Land Surv'rs v. Duncan*, No. AR-84-0239 (Mo. Admin. Hearing Comm'n Nov. 15, 1985) at 125, *aff'd*, 744 S.W.2d 524 (Mo. App. E.D. 1988). A "misrepresentation" is a falsehood or untruth made with the intent of deceit rather than an inadvertent mistake." *Hernandez v. State Bd. of Registration for the Healing Arts*, 936 S.W. 2d 894, 899, n. 3 (Mo. App. W.D. 1997). Fraud is defined "generally under the common law as an intentional perversion of truth to induce another, or to act in reliance upon it." *Id*. at 899 n.2. It necessarily includes dishonesty, which is a lack of integrity or a disposition to defraud or deceive. WEBSTER'S THIRD INTERNATIONAL DICTIONARY 650 (unabr. 1986).

Rotich administered two tablets of Xanax 0.5 mg to a patient P.A., in single tablet doses, at approximately 10:00 p.m. and 7:00 a.m. on his overnight shift. The beginning inventory for that medication was erroneously listed on the CSAR as 8 tablets when there were only 7 in the narcotics box. Although Rotich may not have been responsible for the initial error, he

perpetuated it: first, by not recording the accurate count on the CSAR at the beginning of his shift, and second, by simply subtracting one tablet from the wrong count at each removal instead of taking note of how many tablets actually remained in the box when he removed them.

When Curry arrived for the next shift, she discovered that the count of Xanax 0.5 mg was incorrect and notified Estrada. Rotich then compounded the initial inventory error by changing a CSAR entry for a legitimate dose of Xanax 0.5 mg he had given to a patient to indicate that he actually wasted that tablet. Then, when Estrada confronted Rotich, he initially lied to her, saying he had dropped a tablet in a patient room. After he recanted that story, Rotich returned to the medication room and proceeded to strike through the entry. Then he made a late entry to reflect the withdrawal of the same tablet. Rotich apparently made these false markings on the CSAR to account for the tablet that was presumed missing from the inventory. Rotich knew that neither change to the CSAR was a true and accurate reflection of what happened to the medication because he had administered that particular tablet to P.A. at just after 10:00 p.m. on October 13.

Based on these findings, we find that when Rotich made false entries on the CSAR he did so willfully, so that his supervisors would rely on such documentation and conclude that he had never made an error. In doing so, he committed misconduct, made misrepresentations, was dishonest, and documented fraudulently. We find that Rotich is subject to discipline under § 335.066(5).

Professional Trust – Subdivision (12)

The phrase "professional trust or confidence" is not defined in Chapter 335. Nor has the phrase been defined in case law. Absent a statutory definition, the plain meaning of words used in a statute, as found in the dictionary, is typically relied on. *E&B Granite, Inc. v. Dir. of Revenue*, 331 S.W.3d 314, 318 (Mo. banc 2011). The dictionary definition of "professional" is

> of, relating to, or characteristic of a profession or calling…[;]…
> engaged in one of the learned professions or in an occupation

> requiring a high level of training and proficiency…[; and]…characterized or conforming to the technical or ethical standards of a profession or occupation….

WEBSTER'S THIRD NEW INT'L DICTIONARY UNABRIDGED 1811 (1986). "Trust" is

> assured reliance on some person or thing [;] a confident dependence on the character, ability, strength, or truth of someone or something…[.]

Id. at 2456. "Confidence" is a synonym for "trust." *Id.* at 475 and 2456. Trust "implies an assured attitude toward another which may rest on blended evidence of experience and more subjective grounds such as knowledge, affection, admiration, respect, or reverence[.]" *Id.* at 2456. Confidence "may indicate a feeling of sureness about another that is based on experience and evidence without strong effect of the subjective[.]" *Id.* Therefore, we define professional trust or confidence to mean reliance on the special knowledge and skills that professional licensure evidences.

The Board argues there is cause to discipline Rotich under § 335.066.2(12) not only because of the Xanax incident, but because of the incidents connected with the PIs he received at Kindred before October 14, 2011. Some of the PIs contained in the Board's Exhibit A were not mentioned at all. For those we find we simply have an insufficient evidentiary basis to consider them in relation to the Board's case. Thus, our findings are based only on the PIs about which the chief clinical officer testified.

According to the Board, the PI Rotich received in May 2010 is evidence that he violated professional trust and confidence by leaving a phlebotomist alone with a patient who was a staff assault risk. The Board elicited no testimony about this alleged conduct; its only evidence regarding the incident is a copy of the PI contained in the Exhibit A, which is hearsay. Rotich explained that he accompanied a female phlebotomist to a patient room, at her request, for a blood draw and that he remained in the patient's room with her until she was finished with the

task and left the room. Additionally, Rotich testified that he did not know, until he was confronted about the incident by his supervisor, that the reason the phlebotomist requested Rotich's presence was because the patient presented a known assault risk to female staff. We assess Rotich's testimony on this point and find it to be at least as credible as the uncorroborated hearsay in the Board's record. Given his testimony that he stayed with the phlebotomist as long as requested and that he was not told of the assault risk, we cannot find that Rotich engaged in misconduct on that occasion. The Board did not carry its burden on this point.

But there is cause to discipline Rotich for breaching professional trust and confidence due to his conduct during the Xanax incident. When Rotich attempted to cover up the mistakes he made in keeping an accurate count of Xanax on his shift, he breached the trust of his colleagues and the administrators at Kindred, who rely on RNs to handle and document controlled substances accurately and professionally. Thus, he is subject to discipline under § 335.066.2(12).

Summary

The evidence indicates that Rotich is a kind and caring nurse who made a mistake in documenting the number of Xanax in the narcotics box at the beginning of his shift on October 13, 2011. Unfortunately, instead of simply taking the proper steps to correct the mistake, Rotich tried to cover it up, and thereby greatly compounded his troubles. For this he is subject to discipline, but he will have an opportunity to present evidence to the Board at a subsequent hearing as to the appropriate discipline that will take all relevant circumstances, including his skill and compassion as a nurse, into account.

Rotich is subject to discipline under s 335.066.2(5) and (12).

SO ORDERED on April 24, 2015.

\s\ Karen A. Winn
KAREN A. WINN
Commissioner